STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare at Valerie Manor	1360 Torringford St Torrington, CT 06790

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one sampled resident (Resident #3) who sustained an injury of the toes to the right foot, the facility failed to ensure injuries of unknown origin were thoroughly investigated. The findings include: Resident #3's diagnoses included osteoarthritis, contractures, protein-calorie malnutrition, dementia, anxiety, depression, delusional disorder and psychiatric disturbance. The quarterly MDS assessment dated [DATE] identified that Resident #3 had severely impaired cognition, had no behavioral symptoms, was always incontinent of bowel and bladder and required extensive two-person physical assist with bed mobility and toilet use, and was totally dependent with a two-person physical assist with transfers. The RCP dated 4/27/22 identified Resident #3 required assistance with activities of daily living. Interventions directed if Resident #3 refused a shower to offer a bed bath, report refusals and reapproach as needed. The physician telehealth evaluation note dated 5/30/22 at 10:46 AM identified Resident #3 with bruising to the right great toe and included bases of other toes from an unknown origin. The resident was non-ambulatory. The note further identified that an urgent X-ray of the right great toe and right foot was ordered. The X-ray impressions of the right foot dated 5/30/22 identified possible fracture of the distal 2nd metatarsal (a head of the long bone of the second toe). Further review identified a subtle (not easily seen on an X-ray); acute (occurred suddenly from a traumatic injury) fracture of the 1st proximal phalanx (toe bone that is closest to the metatarsal). There also appeared to be a fracture of the base of the 2nd proximal phalanx. The findings additionally identified osteoporotic changes. Resident #3 was transported to the emergency room for evaluation on 5/30/22. The nursing progress note dated 5/30/22 at 11:00 PM identified Resident #3 returned to the facility from the hospital with a diagnosis of a right foot fracture. A splint application was done with directions to schedule an appointment with a doctor of podiatric medicine as soon as possible. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document, titled Facility Summary Report and dated 6/2/22 identified Resident #3 was using a mechanical lift (Hoyer lift) for transfers in to a tilt in space adapted wheelchair. Further review identified a re-enactment was performed by former ADNS #2 and the charge nurse and hypothesize that the resident's foot may have been inappropriately positioned during Hoyer transfer or perhaps caught up under hooks of air mattress compression box that routinely hangs on the footboard of the resident's bed. Further review identified the resident's care plan was reviewed and revised to reflect the changes and physical therapy evaluation during mechanical lift transfer to ensure safety and proper positioning and to support lower extremities during transfer with mechanical lift. Further interventions included to ensure hooks to air mattress compression box are always covered by a bed pillow. Review of Resident #3's electronic medical record titled Documentation Survey Report for the month of May 2022 identified last documented transferring with two-person physical assist and locomotion on unit with one-person physical assist occurred on 5/25/22 during the 7 AM to 3 PM shift (5 days prior to identification of the resident's right foot injury). Review of a physical therapy (PT) evaluation and plan of treatment dated 6/3/22 identified the reason for referral: the resident was referred to physical therapy to assess safety with transfers and wheelchair positioning following right toe fractures of unknown etiology. Further review identified the resident presented with their right lower extremity slightly off the bed and was re-positioned with the assistance of one person. The evaluation further identnfied nurse aide education was provided on re-positioning and to assess the resident periodically to ensure that the foot was in good position. Review of PT notes dated 6/7/22 identified the resident transferred safely into wheelchair with no contact between right toes and the mechanical lift, wheelchair, or any other surface. The facility was unable to produce investigative documents to provide evidence that a thorough investigation related to fracture of unknown origin of a resident's right foot was conducted. Interview and facility investigation review with the ADNS on 8/14/24 at 1:30 PM identified there should have been 72-hours going back investigation regarding Resident #3's foot injury to determine how the injury happened and to prevent possible further accidents. Although the facility investigation was initiated on 5/30/22, written staff statements failed to identify what happened on five (5) shifts during the 72-hours before identifying the bruising. Review of the facility investigation failed to provide information related to the resident's care that was provided on 5/28/22 during 7AM to 3PM and 11PM to 7AM shifts, and 5/29/22 during the 7AM to 3PM, 3PM to 11PM and 11PM to 7AM shifts. Follow up interview with ADNS identified if all staff were interviewed, then that would be considered a complete investigation. The ADNS indicated she was not employed at the facility in May 2022 and could not explain the reason a thorough investigation had not been completed. Interview with former ADNS #2 on 8/15/24 at 2:50 PM identified she was responsible to ensure that the facility investigation regarding Resident #3's foot injury was completed, and she was unable to remember if agency nursing staff was involved in the resident's care but if she was unable to contact any staff members, she would document that in the investigation. Former ADNS further stated the facility investigated the incident going back 72 hours and determined that the resident's right foot injury could potentially be caused by a mechanical lift transfer. Former ADNS was unable to recall the details of the investigation and was unable to explain why the investigation was not completed. She identified the resident had no known trauma and no recent falls documented. Former ADNS further identified that injuries of unknown origin should be investigated as an allegation of abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Abuse Prohibition policy dated September 2020 identified for protection of residents, any allegation of abuse will be thoroughly investigated. The investigative process includes but is not limited to interviewing staff witnesses or other available witnesses. The facility investigation will be conducted within 5 days of the incident.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one sampled resident reviewed for community discharge (Resident #24), the facility failed to ensure that required discharge information was documented and communicated to Person #10 to ensure a safe and effective discharge. The findings include: Review of Resident #24's clinical record identified a hospital Discharge summary dated [DATE] which identified Resident #24 lived alone at home and was brought to the emergency room when he/she was found wandering and confused. He/she did not remember what happened. The patient was not aware of why he/she was at the hospital and admitted at that time to drinking alcohol daily. There was no clinical evidence of alcohol withdrawl and his/her CIWA (Clinical Institute Withdrawal Assessment for Alcohol scale) remained low. The primary contact person contacted by the hospital identified that the patient was usually disoriented to time and drank alcohol regularly. At discharge the patient was oriented to name and place but disoriented to time and situation and was ambulatory in the room without any assistive device. Further review identified the patient was assessed as needing 24 hour care. Resident #24 was admitted to the facility with diagnoses that included metabolic encephalopathy, alcohol dependence, brain atrophy, Wernicke's encephalopathy (acute neurological condition), brain atrophy, adjustment disorder, anxiety, depression, diabetes and hypothyroidism. The care plan dated [DATE] identified Resident #24 was admitted for short term rehabilitation with plans to discharge home after completion of therapy. Interventions directed discharge planning meetings as needed to evaluate discharge potential, involve family with the resident's permission and set goals to achieve an appropriate discharge. A psychiatric evaluation and consultation note dated [DATE] identified Resident #24 presented with random anxiety and was forgetful and confused throughout the evaluation. The resident stated that if he/she were to go home, he/she would want to drink beer. The resident minimized the severity of alcohol dependence, had random agitation associated with anxiety and remained on every 15-minute checks for three days as ordered. The resident could not recall wanting to leave the facility and was not exhibiting signs or symptoms of psychosis. The social service note dated [DATE] identified the facility reviewed the resident's history with alcohol use, offered to provide information on recovery programs, although the resident declined at that time. The resident further identified they had been to meetings and had been through it before and will let this writer know if they would like to pursue a program. The admission MDS assessment dated [DATE] identified Resident # 24 had severely impaired cognition, used a wander/elopement alarm daily, and was independent with transfer and walking at least 10 feet. The MDS further identified the resident's family and informed the facility that the resident's overall goal for discharge established during the assessment process was to discharge back to the community and active discharge planning was already occurring for the resident to return to the community. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Resident admission Agreement dated [DATE], under section IV Responsible Party Duties, Responsibilities and Liabilities identified an undated handwritten note that Person #10 refused to sign and be responsible. The social service progress note dated [DATE] identified Resident #24 attempted to leave the building. The resident stated he/she wanted to go home. Social Worker #2 called Person #10 to inform him/her of the resident's behaviors and wanting to leave. Person #10 was concerned that the resident would continue drinking when he/she returns home. Social Worker #2 suggested contacting a substance abuse organization to assist the resident. Person #10 stated that the resident may be resistive to participate and did not believe that he/she will go. Further review identified Social Worker #2 informed Person #10 that the resident may not meet level of care to stay at the facility for long term placement, as he/she was independent with his/her activities of daily living. A subsequent social service progress note dated [DATE] identified Person #10 was informed that Resident #24 did not have the type of insurance that would pay for the resident to stay long term at the facility. Person #10 stated that he/she will be meeting with an attorney to start the process for conservatorship. Person #10 asked Social Worker #2 to contact a substance abuse facility for admission for substance use inpatient treatment. Person #10 stated that the resident had been in programs in the past and would say that he/she did not have a problem and did not want to be at the rehabilitation center anymore. Further review identified Social Worker #2 discussed visiting nursing services, and Person #10 stated that the resident may be resistive to allowing anyone into his/her home. Discussion also included Adult Day Center care as an option for the resident during the day, and Person #10 was not sure if the resident would agree to that. Social Worker #2 suggested hiring private caregivers to assist the resident when he/she gets home if he/she has concerns about the resident returning home alone. Person #10 was unsure if there were funds to implement this, as he/she did not have access to the resident's bank information. Social Worker #2 informed Person #10 about other community options, but to make a referral, Person #10 would need to provide the resident's monthly income and any assets. Further review identified that Notice of Medicare Non-Coverage was provided and the appeal process was explained to Person #10. Person #10 chose an option, signed the notice and stated that the resident will have to discharge home on [DATE] as he/she does not have the funds to pay privately. The social service follow-up note dated [DATE] identified Social Worker #2 spoke to a substance use facility to see if they would accept the resident. They responded that there was a two-week waiting list, but they were willing to review a referral and let the social worker know if they would be able to. Social Worker #2 faxed over the referral paperwork. Review of psychiatrist MD #5 evaluation dated [DATE] identified Resident #24 was restless and anxious, with impaired short-term and long-term memory, limited knowledge, disorganized thought process, poor attention span, poor concentration, poor judgment and poor insight. Further review identified the resident presented with Wernick's encephalopathy with related cognitive impairment and restlessness. On evaluation the resident stated he/she does not want to be anywhere other than his/her home. A change in the psychotropic medications' regime was recommended and psychiatry will continue to follow and evaluate as appropriate. A physician's order dated [DATE] directed to continue every 15-minute checks every shift for preventative. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's Discharge Packet signed by Person #10 and dated [DATE] identified the resident was independent with transfers and ambulation in room and was independent with rolling walker in hallway. The Social Services section identified Person #10 had been notified that insurance had stated that they were no longer covering the resident's skilled nursing facility (SNF) stay. Person #10 stated that there was no money for the resident to use to stay at a facility therefore he/she would have to go home. Several referrals were made, and a homecare agency accepted the resident's case and would evaluate for nursing and therapy upon the residents return home. Calls were made to a facility offering outpatient and inpatient treatment (for individuals affected by substance use disorder as well as behavioral health conditions), and voicemails were left with no return call. Person #10 was made aware of the referrals, and he/she said that the resident would have to return home due to lack of money to pay for a skilled nursing facility level of care. The Resident Information section identified Person #10 was responsible for needs or indebtedness and to establish a primary care physician. Further review of the Nursing Discharge Summary failed to identify the resident's mental status, activities of daily living, who was given the discharge medication from the facility, and discharge treatments that included explanation of details of care, treatments, teaching, habits and preferences. Those areas were left blank. The therapy summary section identified Resident #24 was independent with self-care with occasional cueing for initiation and was independent with mobility without assistive device. Home occupational therapy was recommended for home management tasks and community re-entry. The social service note dated [DATE] identified Resident #24 was discharged at 11 AM and Person #10 did not take the resident's medications. Social Worker #2 left a message for Person #10. Person #10 called back at around 3:30 PM and stated that he/she will come back later to pick up the medications and the resident's belongings. Further review identified that Social Worker #2 informed Person #10 that a little after 3 PM on [DATE] the resident was seen by a facility employee walking in his/her town with a brown paper bag, which they presumed was alcohol. When the resident was seen in town, Resident #24 asked the facility employee where his/her home was. Person #10 stated I knew something like that would have happened. Social Worker #2 asked if Person #10 was able to take in the resident for a little bit, but Person #10 was unable to. The facility contacted the town non-emergency line and social worker made a referral to Adult Protective Services. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with Director of Social Services #1 on [DATE] at 9:40 AM identified Resident #24 was discharged home on [DATE] with Person #10 who was identified as the Responsible Party accompanying him/her and home care services to start usually approximately within 24 hours to 48 hours later, unless it was a weekend then it may take longer. The resident lived alone in an apartment and returned to their previous living arrangements. The resident did not have a primary care physician in the community therefore the facility called multiple doctor offices, but they were unable to accept his/her insurance, or they were not accepting new patients. APRN #3 who was following the resident while at the facility, signed home care orders for 30 days to allow time for Person #10 to find a doctor for the resident. The facility made multiple calls to substance use facilities to see if they would accept the resident as previously requested by Person #10 but as of [DATE], the resident's discharge day, the social worker was still waiting for an answer. The Director of Social Services #1 stated that although the resident lived alone, she assumed that Person #10 would provide monitoring and supervision to the resident daily. The resident was not able to care for himself/herself independently, needed reminders, supervision and encouragement. The Director of Social Services #1 stated that Person #10 signed the Discharge Packet for Resident #24, but if Person #10 would not sign the Discharge Packet completed by the facility, the facility would not ask the resident to sign it and would not discharge the resident to the community because he/she was confused and would not be safe alone in his/her home. Further interview identified Resident #24 could have stayed if he/she paid privately when services ended after [DATE] but Person #10 told the facility that the resident had no money, so he/she was taking him/her home. Further interview identified Resident #24 was taken to the hospital on [DATE], a few hours after being discharged from the facility and admitted /re-admitted back to the facility from the hospital on [DATE] because he/she was unsafe to be discharged home. The resident continued to have no payer source but, on this admission, the facility was planning to apply for conservatorship themselves and, if appropriate, Medicaid assistance. Interview and clinical record review with psychiatric APRN #1 on [DATE] at 11:49 AM identified she was not notified about Resident #24's planned discharge to the community on [DATE]. During evaluation on [DATE], the resident was confused and anxious. APRN #1 ordered to continue every 15-minute checks for his/her well-being including elopement. The resident wanted to leave the facility and was saying that he/she lived with a family member although, that family member had been deceased for many years. APRN #1 further identified if asked on [DATE], she would not have recommended discharge, it would not be a safe discharge, but APRN #1 was not sure if the resident's status improved after her evaluation and before discharge on [DATE]. Interview with MD #6 on [DATE] at 12:10 PM identified after receiving denial of payment from the insurance company, social service was trying to work with Person #10 to provide a safe discharge home for the resident. The facility relied on Person #10 to provide support and monitoring. MD #6 further identified the resident made poor choices, should not live by himself/herself, was confused and he/she should have somebody to watch him/her. Person #10 wanted to take the resident home because there was no payer source. Further interview identified if Person #10 did not stay with the resident, It does not sound like that was a safe discharge. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #10 on [DATE] at 1:29 PM identified he/she took Resident #24 home to continue to live alone as previously. Person #10 was aware that the resident will be looking for alcohol after discharge as he/she did before, but no other choices were offered. Person #10 stated that there was no conversation between him/her and the facility that Resident #24 needed increased supervision to be provided by the family after discharge. The facility told him/her that there was no payer source for the resident, therefore he/she had to take the resident home or pay privately for the resident's stay at the facility. Person #10 identified that he/she told the social worker that if he/she leaves his/her apartment, he/she was not sure if the resident would be able to find his/her way back to the apartment. I told her that, but she still said that he/she has to go. Further interview identified that when Person #10 expressed concerns about the discharge, the facility suggested taking the resident home and then look into placement at a substance use treatment facility, that can provide support for someone who cannot live alone. Person #10 stated the resident did not have the money to pay for his/her stay at the facility and added I was basically forced to take him/her home, there were no other options available. Person #10 understood that his/her only choice was to take the resident home to his/her prior living arrangements and home care services will call to schedule home visits. Interview with SW#2 on [DATE] at 1:53 PM identified that she thought Person #10 would help the resident after discharge by providing frequent checks, at least three times a day. SW #2 further stated that she did not speak to Person #10 specifically about this, and she was not sure if the resident was staying home alone. SW #2 identified that the resident required additional services after his/her discharge to community. Interview with DNS on [DATE] at 9:05 AM identified that when a resident is discharged , the social services department initiates the discharge paperwork. Social service completes their section then gives it to nursing to complete their section, and nursing would make a copy of the discharge for the medical record. The DNS was unaware that the nursing part of Resident #24's Discharge Packet was left blank. The DNS stated the resident had diminished decision-making capacity, history of seeking alcohol, requiring frequent redirection and was living alone while in the community. The facility failed to provide evidence that facility staff attempted to provide options for the resident to remain at the facility until additional services were available, failed to ensure that assistance was available immediately after discharge to provide help to the resident who expressed desire to seek alcohol, required increased monitoring and supervision and needed to be assessed for safety in the home environment. In addition, the facility failed to inform the resident and Person #10 of the risks of leaving the facility and staying alone at the apartment without immediate support and care to ensure safety. The Facility initiated unsafe discharge which led to Resident #24's hospitalization approximately four hours after discharge. Review of facility's policy Discharge Planning dated 1/2019 identified the facility will work in conjunction with the resident and interdisciplinary team ensure that necessary education and teaching is provided to resident and/or their next of kin.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, hospital documentation, facility policy, and interviews for one sampled resident (Resident #24) reviewed for admission, the facility failed to accept the resident for a return to the facility after an inadequate discharge plan resulted in hospitalization. This resulted in the resident remaining at the hospital for an extra 8 days until the facility eventually admitted the resident back. The findings include: Resident #24's diagnoses included metabolic encephalopathy, alcohol dependence, brain atrophy, Wernicke's encephalopathy (acute neurological condition), brain atrophy, adjustment disorder, anxiety, depression, diabetes and hypothyroidism. The care plan dated 8/14/24 identified Resident #24 was admitted for short term rehabilitation with plans to discharge home after completion of therapy. Interventions directed discharge planning meetings as needed to evaluate discharge potential, involve family with the resident's permission and set goals to achieve an appropriate discharge. The admission MDS assessment dated [DATE] identified Resident # 24 had severely impaired cognition, used a wander/elopement alarm daily, was independent with transfer and walking at least 10 feet. The social service progress note dated 8/20/24 identified Resident #24 attempted to leave the building. The resident stated he/she wanted to go home. Social Worker #2 called Person #10 to inform him/her of the resident's behaviors and wanting to leave. Person #10 was concerned that the resident would continue drinking when he/she returns home. Social Worker #2 suggested contacting a substance abuse organization to assist the resident. Person #10 stated that the resident may be resistive to participating and did not believe that he/she would go. Further review identified Social Worker #2 informed Person #10 that the resident may not meet the level of care to stay at the facility for long term placement, as he/she was independent with his/her activities of daily living. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent social service progress note dated 8/21/24 identified Person #10 was informed that Resident #24 did not have the type of insurance that would pay for the resident to stay long term at the facility. Person #10 stated that he/she will be meeting with an attorney to start the process for conservatorship. Person #10 asked Social Worker #2 to contact a substance abuse facility for admission for substance use inpatient treatment. Person #10 stated that the resident had been in programs in the past and would say that he/she did not have a problem and did not want to be at the rehabilitation center anymore. Further review identified Social Worker #2 discussed visiting nursing services, and Person #10 stated that the resident may be resistive to allowing anyone into his/her home. Discussion also included Adult Day Center care as an option for the resident during the day, and Person #10 was not sure if the resident would agree to that. Social Worker #2 suggested hiring private caregivers to assist the resident when he/she gets home if he/she has concerns about the resident returning home alone. Person #10 was unsure if there were funds to implement this, as he/she did not have access to the resident's bank information. Social Worker #2 informed Person #10 about other community options, but to make a referral, Person #10 would need to provide the resident's monthly income and any assets. Further review identified that Notice of Medicare Non-Coverage was provided and the appeal process was explained to Person #10. Person #10 chose an option, signed the notice and stated that the resident will have to discharge home on 8/28/24 as he/she does not have the funds to pay privately. The hospital emergency room note dated 8/30/24 identified Resident #24 was discharged from the skilled nursing facility on 8/28/24 with an unsafe plan. The resident was brought to the hospital on 8/28/24. Person #10 stated that the facility told him/her to look into a substance use facility for a placement. Further review identified the resident was discharged from the skilled nursing facility after he/she was deemed medically stable to return home despite concerns about his/her cognitive abilities. The facility attempted to discuss substance use options, but the resident refused. He/she was set up with visiting nurses. Person #10 picked the resident up. Unfortunately, the resident was found lost on the street less than 2 hours after Person #10 dropped him/her off at home and he/she was brought to the emergency room. The resident did not remember how he/she got there and was unable to contribute to history. The resident's alcohol level was 53 (normal range <11mg/dL), likely the resident drank alcohol in the couple of hours after discharge from skilled nursing facility and before coming to the emergency room. The hospital note dated 8/30/24 identified the case manager was working with the skilled nursing facility to discuss placement as they discharged the resident to an unsafe situation. Person #10 was involved however, he/she does not live close and cannot be the primary caregiver for the resident. A follow up note at 1:22 PM identified the skilled nursing facility contended that since the resident had no legal decision maker or long-term payer source, they were unable to accept him/her back into their facility. The skilled nursing facility was aware that the Long-Term Care Ombudsman (LTCO) was notified with regards to an unsafe discharge from the facility on 8/28/24. The hospital emergency room updated note dated 8/30/24 identified Resident #24 had been denied readmission to the skilled nursing facility and furthermore there will be a continued ongoing management case waiting for safe disposition to be implemented. The resident was a flight risk, had been wandering around the department. The plan moving forward was to admit under medicine service for continued social service. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Havencare at Valerie Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1360 Torringford St Torrington, CT 06790	

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital emergency room note dated 9/1/24 identified Resident #24 was with a one to one due to impulsiveness and wanting to go home. Awaiting safe discharge. Further review identified an expected date of discharge 9/2/24. The hospital emergency room note dated 9/2/24 identified the resident needed 24-hour care, and was unable to care for self at home and the case manager was working on a discharge disposition to a skilled nursing facility. The hospital emergency room note dated 9/4/24 identified Resident #24 was oriented to his/her name and place and was disoriented to situation. The resident had poor judgement, only wanted to go back home and was unable to understand what was going on with him/her. The note further identified that the resident was medically stable and was awaiting safe disposition. The hospital note dated 9/9/24 at 4:53 PM identified the Long-Term Care Ombudsman called and stated that the skilled nursing facility will take Resident #24 back and the facility will be applying for conservatorship for the resident. The case management team was updated and will plan for discharge on [DATE]. The facility refused to allow Resident #24 to return to the facility after his/her hospitalization that occurred approximately four hours after discharge from the facility on 9/28/24 to the community and after the resident was medically cleared by the hospital physicians to return to the facility on the same day. This resulted in Resident #24 remaining in the hospital for an extra 8 days until the facility eventually admitted the resident back. Interview with Facility Hospital Liaison #1 on 9/11/24 at 12:30 PM identified the facility would always reoffer a bed when a resident was just discharged from the facility. She further stated that unfortunately, sometimes she responded by phone call and therefore had no documentation that the facility was willing to take the resident back earlier than documented by the hospital. Further interview identified that although the hospital documentation identified that the resident's expected discharge date from the hospital was 9/2/24, she assumed that the resident was not medically stable for discharge. The Facility Hospital Liaison #1 identified that although the skilled nursing facility had appropriate beds available and staff was able to provide care and services that the resident required, the facility had to obtain corporate approval because there was no payer source to pay for the resident's admission to the facility and everything takes time. Resident #24 was admitted to the secured dementia unit on 9/10/24 and the facility was planning to apply for conservatorship for the resident. The facility admission Process policy and procedure identified that priority admission may be granted to certain categories of people that included applicants who were discharged from the facility to the community withing fifteen (15) days of the request for readmission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, staff interview and review of facility policy and procedures for one sampled resident (Resident #11) reviewed for pain management, the facility failed to develop a pain management care plan. The findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses that included displaced fracture of the second cervical vertebra and pain in the left ankle and joints of the left foot. A Minimum Data Set (MDS) assessment dated [DATE] identified the resident had significant cognitive impairment (BIMS of 0) required extensive assistance with activities of daily living. Physician orders dated 12/22/22 directed Tramadol (pian medication) 25 milligrams every 8 hours for severe pain. Review of the medication administration record from 12/22/22 through 12/27/22 identified the resident was reporting pain daily. A subsequent physician order dated 12/27/22, directed 50 milligrams, scheduled two times a day for severe pain. A pain assessment dated [DATE] indicated the resident was not able to vocalize pain, non-verbal pain symptoms were present with facial expressions indicating the pain was increasing with a change in vitals, and the assessor should proceed to the care plan. Subsequent pain assessments dated 1/7/23 and 1/13/23 indicated the resident was vocalizing a dull aching pain, which was frequent on a pain scale of 6, on a scale of 1-10. During an interview and review of the clinical record with the Director of Nurses on 12/23/24 at 12:10PM, failed to identify a pain management care plan had been developed to address Resident #11's pain. Review of the policy and procedure for pain management, dated April 2015 directed the facility will develop and implement interventions and approaches to pain management, both pharmacological and nonpharmacological. A review of the facility policy for Comprehensive Care Plans directed that the Interdisciplinary Team was responsible for developing a comprehensive care plan for each resident that includes measurable objectives and timelines to accommodate preferences, special medical nursing, and psychosocial needs. The Care Plan is evaluated and revised as needed and quarterly.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and interview with facility staff, the facility failed to ensure for 1 of 2 residents reviewed for discharge (Resident #8), the resident received the correct medications upon discharge to home. The findings include: Resident #8's diagnoses included perforated gastric ulcer, peripheral vascular disease, and essential hypertension (high blood pressure). A care plan dated 12/21/21 identified the resident needed assistance with self-care, mobility, and medications for high blood pressure. Interventions included assist with personal care, ambulation, and administration of medications. The Minimum Data Set assessment dated [DATE] identified Resident #8 as cognitively intact (BIMS 14). Resident #8 required extensive assistance with dressing, toileting, showering, and setting up for meals. The assessment further identnfied the Resident was continent of both bowel and bladder function. A physician's order dated 1/4/22 at 10:15 AM indicated Resident # 8 was to be discharged home with medications and services. A nursing progress note dated 1/4/22 at 4:48 PM indicated Resident #8 was discharged home with medications and services via a private car. Review of facility documentation dated 1/4/22 identified discharge medications were reviewed but not reconciled with Person #1 and Resident #8 had been discharged home with two other resident's medications. During an interview on 8/13/24 at 1:10 PM with Social Worker #1 identified medications are to be reconciled with the medication list prior to discharge. Interview on 8/14/24 at 9:50 AM with the Director of Nurses identified medications are to be reviewed, reconciled, and education provided prior to discharge with the resident or responsible party. Interview on 8/14/24 at 10:32 AM with LPN #1 identified she was responsible to review and reconcile medications with Person #1 prior to discharge. LPN # 1 stated that she did not reconcile the medications to ensure the correct medications were given to the resident at the time of discharge.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation and interviews for 1 sampled resident (Resident #16) that required a specialized treatment, the facility failed to provide the treatment. The findings include: Resident #16 had diagnoses of chronic obstructive pulmonary disease, malignant neoplasm of pancreas, disease of the biliary tract, fatty liver and chronic kidney disease. Review of facility documentation dated 8/17/2021identified the Resident had a diagnosis of jaundice with a biliary drain. Review of the Hospital Discharge summary dated [DATE] by Surgeon #1dentified that Resident #16 underwent a biliary stent placement on 8/23/2021 with the plan to leave the tube open to external drainage to the bag until the bilirubin is seen to plateau or decrease. The discharge summary directed flush the biliary tube with 10cc normal saline twice daily to maintain tube patency. Review of the physician's order dated 8/29/2021 directed to cleanse right flank biliary drain site with normal saline and apply split gauze protection dressing every day shift. Further review failed to identify a physician order to flush the biliary tube with 10 cc normal saline twice daily to maintain tube patency as was noted on the hospital discharge summary. Interview with the DNS on 8/20/2024 at 2:30 PM identified that that he was not here at that time and could not speak to the situation. The interview with the Medical Director on 8/22/2024 at 8:30 AM identified that the facility should have followed the hospital discharge summary physician/surgeons' orders.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, interviews with facility staff and review of facility documents for one resident (Resident #20), reviewed for reports of pain, the facility failed to evaluate or develop a plan of care to address pain management. The findings include: Resident #20 was admitted to the facility on [DATE] with diagnoses that included acute pulmonary edema, cellulitis of the left lower limb, pressure ulcer of the sacral region and left buttock. Physician orders dated 6/6/23 directed Acetaminophen 325 milligrams. 2 tablets every 6 hours as needed for pain. An admission Minimum Data Set (MDS) assessment dated [DATE] identified the resident had no cognitive impairment (BIMS of 13), required extensive assistance with activities of daily living, and no reports of pain. Review of the clinical record identified pain assessment dated [DATE] and 6/22/23 indicating the resident was able to vocalize pain and was currently not experiencing pain. Review of the progress notes from 7/2/23 through 7/5/23 identified the resident was reporting a headache daily with reports of pain ranging from a scale of 1 to a scale of 7, on a pain scale of 1-10. Acetaminophen 325 milligrams. 2 tablets were administered daily with varying effect with the resident reporting no effect on 7/3/23. Review of the pain management policy dated April 2015 directed when a resident reports a new onset of pain, a pain evaluation is completed, as well as a physical evaluation and notification to the physician. Identifying the etiology of pain is essential to its management. Additionally, the facility to the extent possible will develop and implement interventions, both pharmacological and nonpharmacological and modify the approaches as necessary. Interview and review of the clinical record with the Director of Nurses on 12/23/23 at 1:00PM, identified that pain evaluations had not been conducted during the period of 7/2/23 through 7/5/23 and a care plan had not been developed to address pain management.